

Resurgence of Leprosy - Increasing Trends in Kollam District, Kerala

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ABSTRACT

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In the efforts to reach the target of elimination of leprosy by the end of year 2005, many measures were being pushed by the leprosy agencies of India with the support of WHO and Global Alliance for Elimination of Leprosy (GAEL).⁷ One such strategy was the Final push of leprosy as strategy was initiated by WHO in November, 1999. The objective was to achieve the elimination target in all countries by end of 2005.

New cases continue to occur in significant numbers, probably the result of a persisting pool of infection. Instead of being intensified, leprosy program has slowed down and is being diluted. With the motive of achieving the elimination targets, corners are being cut. These includes shortage of staff, no active surveillance, integration of leprosy into general medical services, leprosy workers becoming multipurpose workers and diverted to newer priorities such as HIV and TB, and reduction of funds.¹⁰ If this situation is allowed to continue, resurgence of a leprosy epidemic is imminent.

Keywords: Leprosy, NLEP, Case detection, Resurgence.

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Leprosy is a chronic granulomatous disease involving skin, peripheral nerves and nasal mucosa but capable of affecting any tissue or organ. It is a disease associated with significant social stigma and poses a public health problem due to its potential to cause disability in a small proportion of cases. The Govt. of India launched the National Leprosy Eradication Programme (NLEP) in 1983 with the goal of eradicating leprosy by the year 2000. During this phase, the prevalence rate reduced from 24/10000 population in 1992 to 3.7/10000 by March 2001. In 2001 the second phase of National Leprosy Eradication Programme started with the objective of achieving the elimination target by 2005.¹ Elimination in leprosy refers to the stage when its prevalence reaches less than 1 per 10000 population. The Ministry of Health, Government of India formally announced on 30 January 2006 that the country had achieved elimination target as the prevalence rate of leprosy as on 31st December 2005 was 0.95 per 10000.² India contributed approximately 54% of the total number of new cases detected globally in 2006. In India, seven states – namely Bihar, Chhattisgarh, Jharkhand, Maharashtra, Orissa, Uttar Pradesh and West Bengal- contributed to 66% of the country's case load.³

The distribution of leprosy is uneven and shows

clustering not only within states, but also within the smallest community groups such as villages, right up to family level.⁴ Leprosy endemicity is not restricted to rural areas but also affects urban population.⁵ Kerala is among the low endemic states with respect to leprosy prevalence and in March 2009 a prevalence rate of 0.22/10000 had been reported, thus supporting the fact.⁶ But recent trends seem to be contradicting. In this article, we have made an effort to present the status of leprosy cases in Kollam district of Kerala, which may shed light to the current situation. We have the following statistics for the period from July 2010- July 2012 reported in Kollam District.

The total number of new leprosy cases detected was 83, of which 75 (90.3%) were natives of the state and 8 (9.6%) were among the migrant population. Among the 83 cases, 62 (74.6%) were males and 21(25.3%) females with a male : female ratio of 2.95:1. The total number of multi- bacillary cases was 69 (83.1%), while that of pauci-bacillary cases was 14 (16.8%). The age-wise distribution of the number of cases showed maximum number of patients 30 (36.14%) in the age group 10-29 followed by 24 in the age group 30-49 , 21 in the age group 50-69 and 8 in the age group 70-89. The age-group wise distribution of patients is shown in Table number 1. The youngest patient was 10 years old

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and the oldest was 82.

Sl. No.	Age Group	No. of Patients	Percentage
1	10-29	30	36.14
2	30-49	24	28.91
3	50-69	21	25.30
4	70-89	8	9.63

The NLEP- 20 point report for the period March 2008 to March 2010, showed the total number of new cases detected in Kollam District to be 47. 6 Comparing this to the July 2010- July 2012 period, there has been a 76.5% increase in the number of new cases detected. (Figure1)

DISCUSSION

In the efforts to reach the target of elimination of leprosy by the end of year 2005, many measures were being pushed by the leprosy agencies of India with the support of WHO and Global Alliance for Elimination of Leprosy (GAEL).⁷ One such strategy was the Final push of leprosy as strategy was initiated by WHO in November, 1999. The objective was to achieve the elimination target in all countries by end of 2005.

One of the key elements of the final push strategy was the integration of leprosy services into the general health services to improve access to treatment. But

this strategy has given rise to problems such as lack of commitment within the general health services towards implementation of MDT services; failure to redefine the role of the vertical programme after integration and transfer staff to other functions; initial success breeding complacency, so that health services are unable to sustain high MDT coverage; failure to extend MDT services into difficult-to- access areas/populations with weak or non-existent health infrastructure.⁸

Another strategy to reach the elimination target soon was called “Katmandu recommendations” which were new instructions being given to the field staff. The main instruction being to stop all active search for case detection.⁹

From the present study, we attribute the present increase in incidence of leprosy cases in Kollam, Kerala to the following reasons:

1. Immigrants from high- endemic states- many of whom are lost to follow up.
2. Increased incidence of multibacillary cases among the newly diagnosed.
3. Active case detection being replaced by self reporting leading to hidden cases that fail to report to the health facility.
4. Misdiagnosed cases.

New cases continue to occur in significant numbers, probably the result of a persisting pool of infection.

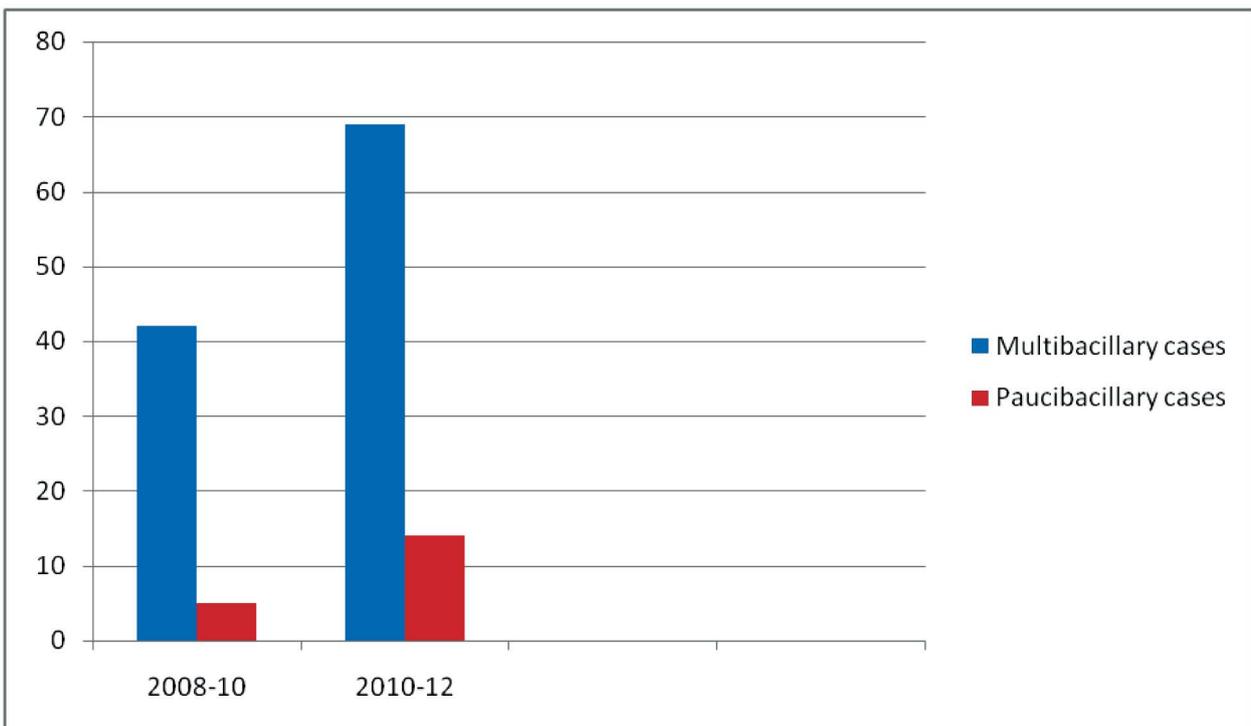


Figure 1. Comparing the new cases detected in 2008-10 & 2010-12

Instead of being intensified, leprosy program has slowed down and is being diluted. With the motive of achieving the elimination targets, corners are being cut. These includes shortage of staff, no active surveillance, integration of leprosy into general medical services, leprosy workers becoming multipurpose workers and diverted to newer priorities such as HIV and TB, and reduction of funds.¹⁰ If this situation is allowed to continue, resurgence of a leprosy epidemic is imminent.

END NOTE

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